CMS-1500 02/12

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY G UMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INS DATE DD SEX F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (St YES NO

OTHER (Desi CC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

NCE ME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES NUC

RE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGN

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the re her info cessar to process this claim. I also request payment of government benefits either t to the p ccepts ment below.

SIGNED E

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREG (LM HER D MM DD YY

15. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERR OVIDER OR OTHER SOU 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM y NUC

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE O URY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Box	Status	Field Title/Description
Patient and Insured Information		
1	**R**	**Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other** Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked. Check Medicaid.
1a	**R**	**Insured's ID Number:** Enter the insured's ID number as shown on insured's ID card. If the patient has a unique member ID assigned by the payer, enter that number in this field. The Montana Medicaid system scans Box 1a, 9a, and 11 for member ID. This is a required field.
2	**R**	**Patient's Name:** Enter the patient's full last name, first name, and middle initial (no period) as indicated on the Medicaid ID card. Last name suffix (e.g., Jr., Sr.) should be added after last name and before first name. Professional suffixes (e.g., Ph.D., M.D., Esq.) should not be included. Use commas between last, first, and middle initial; a hyphen can be used in hyphenated names; do not use periods after middle initial. If the patient's name is the same as the insured's name (i.e., the patient **is** the insured), then it is not necessary to report the patient's name.
3	**R**	**Patient's Birthdate, Sex.** Enter the patient's 8-digit birthday: 2 digits for the month; 2 digits for the day; and 4 digits for the year. Put an X in the applicable M/F box to indicate the recipient's gender. Only one box can be marked. If unknown, leave blank.
4	**C**	**Insured's Name (Last Name, First Name, Middle Initial).** Enter insured's full last name, first name, and middle initial (no period) as indicated on the Medicaid ID card. Last name suffix (e.g., Jr., Sr.) should be added after last name and before first name. Professional suffixes (e.g., Ph.D., M.D., Esq.) should not be included. Use commas between last, first, and middle initial; a hyphen can be used in hyphenated names; do not use periods after middle initial.
5	**R**	**Patient's Address.** Includes multiple fields. Enter the patient's address. Do not use punctuation (i.e., commas periods) or symbols in address except hyphen in ZIP+4. Address includes number, street, city, state (2 characters), and ZIP code. Patient's telephone number includes area code.
6	**C**	**Patient Relationship to Insured.** Enter an X in the applicable box to indicate the patient's relationship to insured. Only one box can be marked: self, spouse, child, other.
7	**C**	**Insured's Address.** Includes multiple fields. Enter the insured's address. Do not use punctuation (i.e., commas periods) or symbols in address except hyphen in ZIP+4. Address includes number, street, city, state (2 characters), and ZIP code. **The NUCC recommends that the phone number not be reported; extensions are not supported.**
8	**O**	**Reserved for NUCC use.** Previously used to report Patient Status; however, that field does not exist in 5010A1 so the field has been eliminated.
9	**C**	**Other Insured's Name.** Indicates there is a holder of another policy that may cover the patient. If Box 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Box 2. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt., Dr.) and professional suffixes (e.g., Ph.D., M.D., Esq.) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.
9a	**R**	**Other Insured's Policy or Group Number.** Enter the policy or group number of the other insured. Do not use a hyphen or space as a separator within the policy or group number. The Other Insured's Policy or Group Number identifies the policy or group number for coverage of the insured as indicated in Box 9. **Montana Medicaid scans Box 1a, 9a, 11 for insured's ID.**
9b	**O**	**Reserved for NUCC Use.** This field was previously used to report Other Insured's Date of Birth, Sex.; that field does not exist in 5010A1; therefore, this field has been eliminated. This field is reserved for NUCC use and NUCC will provide instructions for any use of this field.
9c	**O**	**Reserved for NUCC Use.** This field was previously used to report Employer's Name or School Name; this field does not exist in 5010A1; therefore, this field has been eliminated. This field is reserved for NUCC use and NUCC will provide instructions for any use of this field.
9d	**C**	**Insurance Plan Name or Program Name.** Enter the other insured's insurance plan or program name. The Insurance Plan Name or Program Name identifies the name of the plan or program of the insured as indicated in Box 9.

Box	Status	Field Title/Description
10a–c	C	**Is Patient's Condition Related To.** When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Box 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code where the accident occurred must be reported if Ye" is marked in 10b for Auto Accident. Any item marked Yes indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Primary insurance information must then be shown in Box 11. This information indicates whether the patient's illness or injury is related to employment, auto, or other accident. Employment (current or previous) indicates that the condition is related to the patient's job or workplace. Auto indicates that the condition is the result of an automobile accident. Other indicates that the condition is the result of any other accident type.
10d	C	**Claim Codes (designated by NUCC).** When applicable, use to report appropriate claim codes. Applicable claim codes are designated by NUCC. Refer to current instructions from the public or private payer regarding the need to report claim codes. When required by payers to provide the subset of Condition Codes approved by NUCC, enter the Condition Code here. The Condition Codes approved for use on the CMS-1500 are available at www.nucc.org under Code Sets. When reporting more than one code, enter three blank spaces and then the next code. Montana Medicaid previously scanned this box for member ID; however, this is no longer true; the system scans Box 1a, 9a, and 11 for member ID.
11	C	**Insured's Policy Group or FECA Number.** Enter the insured's policy or group number as it appears on the insured's ID card. If Box 4 is completed, then this field should be completed. Do not use a hyphen or space as a separator within the policy or group number. This number is the alphanumeric identifier for the health, auto, or other insurance plan coverage. The FECA number is the 9-digit alphanumeric identifier assigned to a patient claiming work-related conditions under the Federal Employees Compensation Act 5 USC 8101.
11a	C	**Insured's Birthdate, Sex.** Enter the 8-digit date of birth (MM|DD|YYYY) of the insured. Enter an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank. Insured's Date of Birth is the birth date of the insured indicated in Box 1a. Insured's Sex is the sex (gender) of the insured indicated in Box 1a.
11b	C	**Other Claim ID (Designated by NUCC).** Applicable claim identifiers are designated by NUCC. The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number. Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.
11c	C	**Insurance Plan Name or Program Name.** Enter the name of the insurance plan or program of the insured as indicated in Box 1a. Some payers require an identification number of the primary insurer rather than the name in this field.
11d	C	**Is There Another Health Benefit Plan?** When appropriate, enter an X in the correct box. Yes indicates that the patient has insurance coverage other than the plan indicated in Box 1. The non-NPI number of the billing provider refers to the payer assigned unique identifier of the professional. If marked Yes, complete 9, 9a, and 9d.
12	R	**Patient's or Authorized Person's Signature and Date of Signature**. Read back of form before completing and signing. Enter Signature on File, SOF, or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter No Signature on File. Patient's or Authorized Person's Signature indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim.
13	C	**Insured's or Authorized Person's Signature.** Enter Signature on File, SOF, or legal signature. If there is no signature on file, leave blank or enter No Signature on File. Insured's or Authorized Person's Signature indicates there is a signature on file authorizing payment of medical benefits.
14	C	**Date of Current Illness, Injury, or Pregnancy (LMP).** Identifies the first date of onset of illness, the actual date of injury, or the LMP for pregnancy. Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier (431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period) to identify which date is being reported. Enter the qualifier to the right of the vertical, dotted line.

Box	Status	Field Title/Description
15	C	**Other Date.** Identifies additional date information about the patient's condition or treatment. If patient had same/similar illness, enter other date and qualifier. Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier (454 Initial Treatment; 304 Latest Visit or Consultation; 453 Acute Manifestation of a Chronic Condition; 439 Accident; 455 Last X-ray; 471 Prescription; 090 Report Start (Assumed Care Date); 091 Report End (Relinquished Care Date); 444 First Visit or Consultation) to identify which date is being reported. Enter the qualifier between the left-hand set of vertical, dotted lines.
16	C	**Dates Patient Unable to Work in Current Occupation. T**he time span the patient is or was unable to work. If the patient is employed and is unable to work in current occupation, a 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. Date must be shown for the From/To dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.
Provider Information		
17	C	**Name of Referring Provider or Other Source**. The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the services or supplies on the claim. The qualifier indicates the role of the provider being reported. Enter the first name, middle initial, and last name followed by the credentials of the professional who referred or ordered the services or supplies) on the claim. If multiple providers are involved, enter one provider using the priority order 1. Referring provider (DN); 2. Ordering provider (DK) 3. Supervising provider (DQ). Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. The field allows for 2 characters to the left of the dotted line and 24 to the right of the dotted line.
17a	C	**Unlabeled.** This field allows for the entry of 2 characters in the qualifier field and 17 characters in the Other ID # field. **Montana Medicaid reserved for 7-digit Passport referral number.**
17b	C	**NPI #.** Refers to the 10-digit HIPAA National Provider Identifier of the referring, ordering, or supervising provider. **Montana Medicaid reserved for Indian Health Services referral number.**
18	C	**Hospitalization Dates Related to Current Services**. Refers to an inpatient stay and indicates the admission (To) and discharge (From) dates associated with the services on the claim. Complete this field when medical service is furnished as a result of, or subsequent to, a related hospitalization. Enter the inpatient 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date, or if not discharged, leave field blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	C	**Additional Claim Information (Designated by NUCC)**. Enter the inpatient 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization. NUCC defines the provider taxonomy qualifier as ZZ for the CMS-1500.
20	C	**Outside Lab? $ Charges**. Put an X in the appropriate Yes/No box. Selecting Yes indicates that the reported service was provided by an entity other than the billing provider (e.g., services subject to Medicare's anti-markup rule). Selecting No or leaving blank indicates that no purchased services are included on the claim. If Yes is checked, enter the purchase price under $Charges and complete Box 32. Each purchased service must be reported on a separate claim form because only one charge can be entered. When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.
21	R	**Diagnosis or Nature of Illness or Injury. ICD Indicator.** ICD Indicator identifies the version of the ICD code set being reported. Diagnosis or Nature of Illness or Injury is the sign, symptom, complaint, or condition of the patient relating to the services on the claim. Enter the applicable ICD indicator to identify which version of ICD codes (9 ICD-9 or 0 ICD-10) is being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. **Until ICD-10 is implemented, Montana Medicaid will only accept 4 diagnosis codes. Use Boxes A–D. Once ICD-10 is implemented, Montana Medicaid will accept Boxes A–L.** List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A–L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

Box	Status	Field Title/Description
22	**C**	**Resubmission and/or Original Reference Number.** This field allows for the entry of 11 characters in the Code area and 18 characters in the Original Ref. No. box. List the original reference number for resubmitted claims. Refer to the current instructions from the public or private payer regarding the use of this field (e.g., code). When resubmitting a claim, enter the appropriate bill frequency code (7 Replacement of prior claim; 8 Void/cancel of prior claim) left justified in the left-hand side of the field. Not intended for use for original claim submissions. *Resubmission* means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.
23	**C**	**Prior Authorization Number.** The payer assigned number authorizing the services. Enter prior authorization number [or referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number] as assigned by the payer for the current service. Do not enter hyphens or spaces within the number. **Montana Medicaid reserves this box for prior authorization.**
24	**O**	Supplemental information can only be entered with a corresponding, completed service line. The six service lines in this section have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. **The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.** The supplemental information is to be placed in the shaded area of 24A–24G as defined in each box. Providers must verify requirements for this supplemental information with the payer.
24A	**R**	**Dates of Service.** Indicates the month, day, and year the services were provided. In the **bottom, white half** of the claim line, enter the From and To dates of service. Enter From/To dates of service. If there is only one date of service, enter that date under From. Leave the To blank or enter the same date as in the To field. Allows for the entry of 2 characters under MM, 2 characters under DD, and 2 characters under YY in each of the unshaded date fields. Grouping services refers to a charge for a series of identical services without listing each date of service. If grouping services, the place of service, procedure code, charges, and individual provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G. When required by payers to provide additional narrative description of an unspecified code, NDC, contract rate, or tooth numbers and areas of the oral cavity enter the applicable qualifier and number/code/information starting with the first space in the shaded line of this field. Do not enter a space, hyphen, or other separator between the qualifier and the number/code/ information. The information may extend to 24G. Additional information and examples can be found on the NUCC website. See link in footer below.
24B	**R**	**Place of Service.** For each item used or service performed, enter the appropriate two-digit place of service code in the **bottom, unshaded half** of the claim line. See the Place of Service Code list at www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf.
24C	**C**	**EMG.** Identifies whether the services was an emergency. Check with payer to determine if the emergency indicator) is necessary. If required, enter Y for Yes in the bottom, unshaded area of the field. Leave blank for No. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts, or as defined in 5010A1.
24D	**R**	**Procedures, Services, or Supplies.** Identifies the medical services or procedures provided to the patient. Enter the CPT or HCPCS codes and, if applicable, modifiers from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four 2-digit modifiers. The specific procedure codes must be shown without a narrative description. Enter the procedure code, and if applicable, the 2-digit modifier in the appropriate fields.
24E	**R**	**Diagnosis Pointer.** The line letter from Box 21 that relates to the reason the services were performed. Enter the diagnosis code pointer (reference letter) as shown in Box 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letters should be A–L or multiple letters as applicable. ICD-9 or ICD-10 (once mandated) diagnosis codes must be entered in Box 21 only. Do not enter them in 24E. Enter letters left justified in the field. Do not use commas between the letters.
24F	**R**	**Charges.** The total billed amount for each service line. Enter the charge for each listed service. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Box	Status	Field Title/Description
24G	**R**	**Days or Units.** The number of days corresponding to the dates entered in 24A or units as defined in CPT or HCPCS coding manuals. Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point. Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (e.g., "daily management"). This field allows for the entry of 3 characters in the unshaded area.
24H	**C**	**EPSDT/Family Plan.** Identifies certain services that may be covered under some state plans. Enter the response in the shaded portion of the field: If there is no state requirement to report a reason code for EPDST, enter Y for Yes or N for No only (one character). • If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (Do not enter a Y/N response with the code.) The two character code is right justified in the shaded area of the field. • If the service is Family Planning, enter Y (Yes) or N (No") in the bottom, white area of the field.
24I	**R**	**ID Qualifier.** Enter ZZ for taxonomy qualifier. Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area.
24J	**R**	**Rendering Provider ID #.** Reported in 24J and the qualifier indicating if the number is a non-NPI is reported in 24I. The non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional. The individual rendering the service should be reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The rendering provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b. Enter numbers left justified in the field.
25	**R**	**Federal Tax ID Number. Provide EIN or SSN.** Federal Tax ID Number is the unique identifier assigned by a federal or state agency. Enter the employer ID number or SSN of the billing provider identified in Box 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked. Do not enter hyphens with numbers. Enter numbers left justified in the field.
26	**C**	**Patient's Account No.** The identifier assigned by the provider. Enter the patient's account number assigned by the provider of service's or supplier's accounting system. Do not enter hyphens with numbers. Enter numbers left justified in the field. This field allows for the entry of 14 characters.
27	**R**	**Accept Assignment?** Indicates that the provider agrees to accept assignment under the terms of the payer's program. Enter an X in the correct box. Only one box can be marked.
28	**R**	Total Charge. the total billed amount for all services entered in 24F (Lines 1–6). Enter total charges for the services (i.e., total of all charges in 24F). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.
29	**C**	**Amount Paid.** the payment received from the patient or other payers. Enter total amount the patient and/or other payers paid on the covered services only. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number. This field allows for the entry of 6 characters to the left of the vertical line and 2 characters to the right of the vertical line. **Montana Medicaid reserved for third party liability payments.**
30	**OTH**	**Reserved for NUCC Use.** This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field. This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated.
31	**R**	**Signature of Physician or Supplier Including Degree or Credentials.** Refers to the authorized or accountable person and the degree, credentials, or title. This does not exist in 5010A1. Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

Box	Status	Field Title/Description
32	**C**	**Service Facility Location Information.** Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier. If the Service Facility Location is a component or subpart of the billing provider and they have their own NPI that is reported on the claim, then the subpart is reported as the billing provider and Service Facility Location is not used. When reporting an NPI in the Service Facility Location, the entity must be an external organization to the billing provider.
32a	**C**	**NPI #.** Enter the NPI number of the service facility location only when the service facility NPI is different from the billing provider NPI. This field allows for the entry of 10 characters.
32b	**C**	**Other ID.** Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. NUCC defines the qualifiers used in 5010A1 as 0B – State License Number; G2 – Provider Commercial Number; LU – Location Number. The non-NPI number of the service facility is the payer assigned unique identifier of the facility. This field allows for the entry of 14 characters.
33	**R**	**Billing Provider Info and Phone Number.** Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information as (1) Name; (2) Address, and (3) City, State, and ZIP Code. Do not use commas, periods, or other symbols in the address. Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code (ZIP+4) including the hyphen. Do not use a hyphen or space as a separator within the telephone number.
33a	**R**	**NPI #.** Enter NPI for the billing provider.
33b	**R**	**Other ID.** The non-NPI ID number of the billing provider refers to the payer assigned unique identifier of the professional. ZZ remains the qualifier for the CMS-1500. Enter the ZZ qualifier (provider taxonomy) followed by the ID number. Atypical providers should enter the G2 qualifier followed by their 7-digit provider ID (e.g., G2XXXXXXX). The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field.